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Maternity Reports: LSA DHMU Supervisory Roadshow 11th March 2015

Patterson, D., & Moorhead, C. (2015). *Maternity Reports: LSA DHMU Supervisory Roadshow 11th March 2015*. LSA DHMU Supervisory Roadshow, Newry, United Kingdom.

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Maternity Reports

**LSA DHMU Supervisory
Roadshow 11th March 2015**

Outline of session

By the end of the session you will be able to discuss the following reports and their relevance to midwifery practice

- Extraordinary LSA review HSSD Guernsey (2014)
- The Report of the Morecambe Bay Investigation (Kirkup, 2015)
- Ombudsman Report (2013)
- Midwifery supervision and regulation: recommendations for change. (2013)
- Kings Fund Report (2014)
- MBRRACE (2015)

NHS England South West Guernsey LSA Extraordinary Review

Area visited were 1-3 October 2014.

1. Princess Elizabeth Hospital, Health and Social Care Services (HSSD), Guernsey
 2. Jersey General Hospital, St Helier, Jersey
- The NMC were initially informed about escalating concerns about the supervision of midwifery and the provision of midwifery care within maternity services
 - 6 Areas around supervision were identified that did not comply with the Midwives Rules and Standards

Concerns around supervision

6 Areas around supervision were identified that did not comply with the Midwives Rules and Standards

Midwives rules and standards not met around

- Submission of ITP's
- Safe retention of records
- Lack of clear policy and procedure for the recruitment of SoMs
- Midwives failing to maintain their midwifery registration
- LSAs do not complete supervisory investigations in an open, fair and timely manner

Additional concerns involving direct care

The additional concerns reported fall within the following themes:

- 1. The care environment
- 2. Policies and procedures
- 3. Governance
- 4. Leadership and management
- 5. Organisational culture

Care environment

- Stories about poor maternity care and experiences of women .
- Women were afraid to complain - have to use the service in another pregnancy.
- One mother reported being refused a shower after giving birth in the delivery room
- One mother was coerced into breastfeeding her baby despite rapidly decreasing weight loss
- Water births were not always available
- Student nurses stated that some midwives were judgmental and lacked empathy towards women.
- Out of date birthing environment which is very 'clinical' and in need of modernisation to reflect contemporary maternity services.

Policies and procedures

- Many processes for policy and procedures are either under review or are at an early stage of implementation
- Standing orders had recently been in use
- Guidelines were not written by the multi-professional team but were written by the senior governance team and then put out for consultation via email.
- Guidelines were not always accessible
- For new staff no robust induction programme in place

Governance

- Staff unfamiliar with the practice of incident reporting - including those with a risk management role
- Delays in investigations because of lack of scrutiny and rigour in risk management processes.
- Non-attendance of senior managers and clinical governance committee meetings
- Unsecure storage of records- records missing/ stored in areas with open doors and unlocked filing cabinets accessible to the public
- Education and training needs – midwives received mandatory training but limited other CPD
- Student nurses felt unsupported and unwelcome

Leadership and management

- Midwives reported a lack of clinical leadership and management within the maternity services.
- Lack of responsibility to appropriately prepare and support new staff, for example, new midwives, including agency and bank midwives.
- Limited evidence of a robust induction or any preceptorship of new staff.

Organisational culture

- The term the “Guernsey way” was frequently referred to by midwifery staff to describe behaviours and/or practices.
- Midwives who challenged working practices were unsupported and eventually left
- Midwives reported that they were disciplined if they raised concerns
- Midwives were discouraged from calling consultants, particularly after 17.00 and out of hours.
- Described by some midwives as hierarchical, medically dominated, management focused and led rather than woman centred.

conclusion

Due to the enforced leave of absence of Guernsey SoMs from their SoM role pending a review into their competence and capability as a SoM. There was a

- lack of interface between midwifery supervision and clinical governance in HSSD Guernsey
- Not assured that SoMs conducted investigations in an open, fair and timely manner
- Risks are not controlled to ensure supervision of midwifery meets the Midwives rules and standards (NMC, 2012) and LSA standards to protect the public.

The Report of the Morecambe Bay Investigation

An independent investigation into maternity and neonatal services at the University Hospitals of Morecambe Bay NHS Foundation Trust from January 2004 to June 2013

This Report details a distressing chain of events that began with serious failures of clinical care in the maternity unit at Furness General Hospital,

Dr Bill Kirkup CBE March 2015

Rationale

- Established by the Secretary of State for Health to examine concerns raised by the occurrence of serious incidents in maternity services provided by what became the University Hospitals of Morecambe Bay NHS Foundation Trust (the Trust)
- Investigated 16 neonatal deaths and 3 maternal deaths- found concerns over 11 neonatal deaths and 1 maternal death
- Relatives of those harmed, expressed concern over the incidents and why they happened, and over the responses to them by the Trust and by the wider National Health Service (NHS), including regulatory and other bodies.

Executive summary

Dysfunctional nature of the maternity service

- Clinical competence was substandard, with deficient skills and knowledge
- Working relationships were extremely poor between midwives and doctors
- A growing move amongst midwives to pursue normal childbirth 'at any cost'
- Women were inappropriately accessed as low risk
- Late referral of women to the obstetric team
- Failure of obstetric team to question such practices

continued

- Failures of risk assessment and care planning that resulted in inappropriate and unsafe care
- Response to adverse incidents was grossly deficient, with repeated failure to investigate properly and learn lessons
- Found 20 instances of significant or major failures of care
- Resulting in 1 maternal death and the deaths of 11 babies.

Causes of Deaths

- Fetal hypoxia in labour – h/o prev IUGR no growth scans viewed as low risk
- Untreated high blood pressure – mother cardiac arrest and died
- Unrecognised sepsis in a baby

All demonstrated

- poor clinical competence,
- insufficient recognition of risk,
- inappropriate pursuit of normal childbirth and
- failures of team-working
- Initial investigation were deficient and failed to identify manifest problems.
- Supervisor of midwives investigations were flawed, relying on poor-quality records that conflicted with patients' and relatives' accounts.

For the Trust, key recommendations

- Apologies to families
- Review of skills, training and duties of care;
- Improved team working
- Improved risk assessment
- Audit of maternity and paediatric services;
- Reviewing incident reporting and investigation, complaint handling and clinical leadership

Ombudsman report (2013)

Background / case study –

- Investigation of how complaints (4 by the Father and 1 by the Grandfather) were handled around the unavoidable death of a baby in 2008.
- Prior to this there had been 2 external reviews, LSA Report and an inquest
- 25th Oct Mother had spontaneous rupture of membranes around term went to Furness General Hospital Maternity Unit
- Had complained to the midwife of being unwell the week before - headaches and sore throat –this discussion was not recorded
- Sent home returned asked to return next day – did return sent home again not in labour
- Returned following day 27th Oct in labour give birth to a baby boy
- Birth and A/S were described as normal in the records – baby cried immediately at birth and didn't require any intervention.

Continued

- Father account was different – baby did not cry at birth and required O2
- First 25 hours of babies life was not recorded – chart went missing including observation sheet
- 27th Oct following birth the mother became ill with pyrexia IV antibiotics were administered
- Baby was described by father as wheezy mucousy and breathing fast
- Temperature was low between 35.8 and 36.1 paed's were too busy to review baby. Transferred to heated cot twice by midwife
- 28th Oct at 10.30 mother became very concerned re babies condition asked for Paed to see.
- Condition continued to deteriorate and he was transferred to two different Trusts for intensive treatment.
- On 5 November 2008 baby sadly died from pneumococcal septicaemia

Findings of the report

- The Trust did not answer the family's questions openly and honestly and did not learn from what they found.
- A lack of openness by the Trust and the quality of their investigations of these complaints caused a loss of trust and further pain for the family.
- Early records were found to be missing
- Statements from staff had been rewritten and changed
- Evidence found of collusion amongst midwives about the fluctuation of the baby's temperature in preparation for the inquest.
- A change in culture is needed on how complaints are dealt with at both Board and Trust level

Midwifery supervision and regulation: recommendations for change. (2013)

Report following the completion of three investigations into complaints from three families

- Identified that midwifery supervision and regulatory arrangements at local level failed to identify poor midwifery practice
- Current systems do not always allow information about poor care to be escalated effectively into hospital clinical governance or the regulatory system.
- Fail to learn from mistakes
- Midwifery supervision and regulation should be separated;
- NMC should be in direct control of regulatory activity.

Disadvantages of supervision

- The dual role of a Supervisor, providing support but also a regulatory function, allows for an inherent conflict of interest.
- The fact that the Supervisor can be a peer allows for a further conflict, because of a natural desire to support and protect a colleague while at the same time fulfilling an important regulatory role.
- The confidentiality of the Supervisor of Midwives' role can impede hospital investigations and can prevent potentially valuable information coming to light.
- Midwifery Officers are appointed locally rather than by the NMC. This means the NMC has limited control over the quality of the Midwifery Officers.
- There is a weak evidence base in terms of risk for the continuation of an additional tier of regulation for midwives.

In conclusion – NMC

“Midwifery supervision may have real merits in the support it provides for midwives across the country on a daily basis. However, those strengths do not extend to the regulatory role of supervision.”

- The LSA - protect the public by taking immediate suspension of practice
- Midwives' entitlement to supervision and support is protected by its statutory framework.
- Where investigations are conducted well by Supervisors, this makes for a more effective and cost-effective investigation stage on the part of the NMC following a referral.

The King's Fund

Date:01/05/2015

The Nursing and Midwifery Council (NMC) commissioned The King's Fund to carry out an independent review into the regulation of midwives.

- This was the first review of the statutory framework of midwifery regulation since midwives became a regulated profession in 1902.
- The review follows the publication of a report by the Parliamentary and Health Service Ombudsman in England, [Midwifery supervision and regulation: recommendations for change](#).
- The review considered the concerns identified in the report, in particular the potential conflict of interest between Supervisors of Midwives' regulatory and supervisory roles.

Summary of findings

- lack of evidence about the safety and efficacy of secondary regulation ie SoM.
- No evidence that Som is either less or more safe for mothers and babies than other regulatory approaches.
- Current system , with its 'extra layer' of regulation, is confusing for patients and the public.
- It can also result in a lack of clarity for providers of maternity services over management and SoM investigations .
- Recommend that the additional layer of regulation currently in place for midwives should end.
- 28th January the NMC Council accepted the key recommendation of the Kings Fund Review into statutory supervision of midwives

Next steps

- A change in the order will be necessary NMC must have the support of Government and Department's of Health
- Must also consult with registrants
- Interim changes may be put in place eg amendments to Midwives rules and standards



Saving Lives, Improving Mothers' Care: Executive Summary



Maternal deaths have decreased

from **11** to **10** per 100,000 women giving birth

2006-08 2010-12

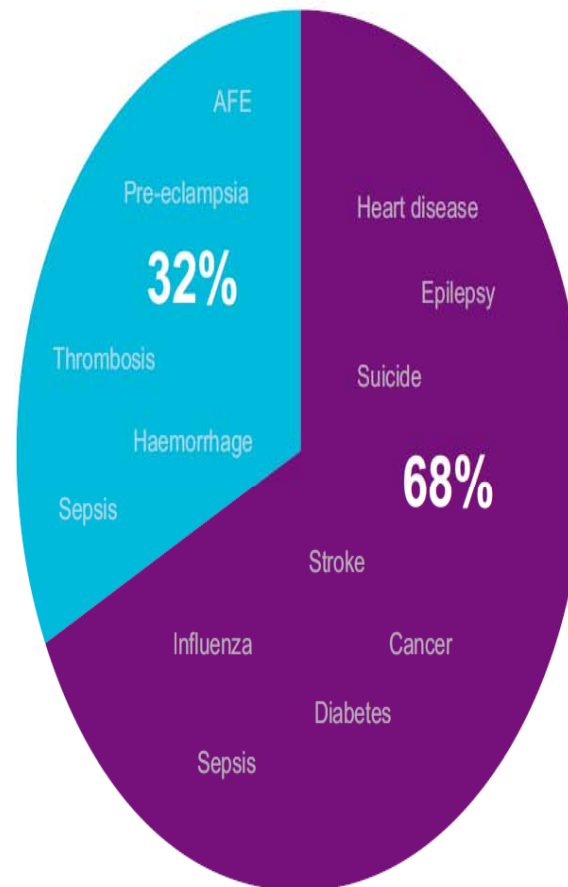
Causes of mothers' deaths

Two thirds of mothers died from medical and mental health problems in pregnancy and **only one third** from direct complications of pregnancy such as bleeding.

Three quarters of women who died had medical or mental health problems before they became pregnant.

Women with pre-existing medical and mental health problems need:

- Pre-pregnancy advice
- Joint specialist and maternity care



Think Sepsis



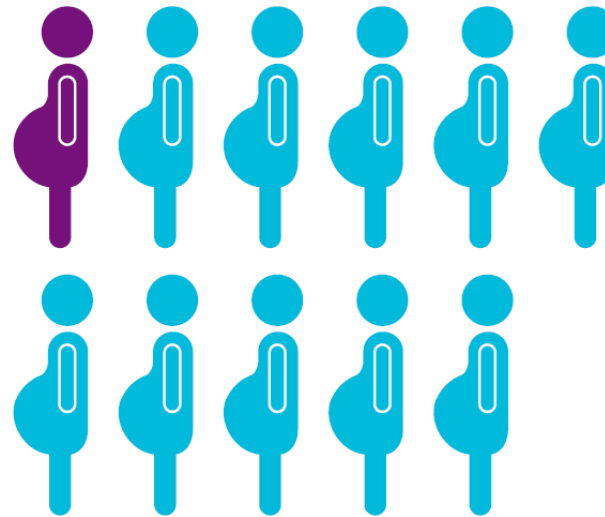
Almost a quarter of women who died had **Sepsis** (severe infection).

Women with sepsis need:

- Early diagnosis
- Rapid antibiotics
- Review by senior doctors and midwives

Prompt treatment and action can make the difference between life and death

Prevent Flu



1 in 11 of the women died from **Flu**

More than half of these women's deaths could have been prevented by a flu jab.

Flu vaccination will save mothers' and babies' lives

Websites

Extraordinary LSA review HSSD Guernsey (2012) accessed at

[http://www.nmc-uk.org/Documents/MidwiferyExtraordinaryReviewReports/Summary%20of%20additional%20evidence PEH Guernsey.pdf](http://www.nmc-uk.org/Documents/MidwiferyExtraordinaryReviewReports/Summary%20of%20additional%20evidence%20PEH%20Guernsey.pdf)

Kirkup Report 2015 accessed at

<https://www.gov.uk/government/publications/morecambe-bay-investigation-report>

continued

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<http://www.nmc-uk.org/Documents/Press/Midwifery%20reg%20review%20draft%20ToR%20v4.pdf>

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The Kings fund report on Midwifery Regulation (2015)

<http://www.kingsfund.org.uk/projects/midwifery-regulation-united-kingdom>

Saving Lives Improving Mothers Care (2015)

<https://www.npeu.ox.ac.uk/downloads/files/mbrbrace-uk/reports/Saving%20Lives%20Improving%20Mothers%20Care%20report%202014%20Executive%20Summary.pdf>